Her Majesty's Coroner
Staffordshire (South) Coroner's Jurisdiction

Date: 30 July 2021

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Temporary Chief Constable, Staffordshire Police

CORONER: I am Mr Andrew A Haigh Senior Coroner for Staffordshire South

1. **CORONER'S LEGAL POWERS**
I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

2. **INVESTIGATION and INQUEST**
On 23 March 2021 I commenced an investigation into the death of Amanda DUNN. The investigation concluded at the end of the inquest on 29 July 2021. The conclusion of the inquest was 'suicide while suffering anxiety and depression' with the cause of Ms Dunn's death being 'mixed drug toxicity'.

3. **CIRCUMSTANCES OF THE DEATH**
Amanda Dunn died at home on 21 March 2021 from a massive self-administered overdose of prescribed medication. She had a history of mental illness and also had caring responsibilities but a major reason for her fatal actions was an ongoing problem with neighbours.

4. **CORONER'S CONCERN**
During the course of the inquest the evidence revealed a matter giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

5. The **MATTER OF CONCERN** is as follows:
Family members told me that for a period of about two years prior to her death Amanda had received a lot of aggravation from a set of neighbours. Police were contacted several times but took no action. The evidence I heard clearly seemed to amount to harassment. Prior to the inquest I was not aware of the full extent of the concerns and had not requested evidence from the police on this (PC [redacted] gave evidence about the circumstances of the death itself). I realise therefore that I have only heard one side of the story but there is a real concern that police are seeking to brush such incidents under the carpet and not taking them sufficiently seriously. Clearly, I do not

want another death reported to me of a similar nature.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 24 September. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8. COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to Amanda's family.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form.

He may send a copy of this report to any person who he believes may find it useful or of interest.

You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

30 July 2021

Andrew A Haigh
HM Senior Coroner for Staffordshire South